

Medicaid MCO Complaints

**Medicaid Prompt Payment Compliance Branch
Department of Insurance**

**Presentation at the Fall Provider Workshops sponsored by the
Department for Medicaid Services and HP Enterprises**

The Medicaid Prompt Payment Compliance (MPPC) Branch was created to assist health care providers on payment issues with the Managed Care Organizations (MCO) operating in Kentucky.

One main function of MPPC Branch is the facilitation of prompt payment and any willing provider complaints as governed by the Kentucky Revised Statutes and Kentucky Administrative Regulations.

KRS 304.17A-702 –

Claims payment timeframes – Duties of insurer

- Requires “clean” claims to be paid, contested or denied within 30 days of receipt.

Note: A “clean” claim is a properly completed billing instrument – paper or electronic – including the required health claim attachments and submitted in the form outlined in statute.

KRS 304.17A-700

“Clean Claim”

means a **properly completed billing instrument**, paper or electronic, including the **required health claim attachments**, submitted in the following applicable form:

- (a) A clean claim from an institutional provider shall consist of:
 - 1. The UB-92 data set or its successor submitted on the designated paper or electronic format as adopted by the NUBC;
 - 2. Entries stated as mandatory by the NUBC; and
 - 3. Any state-designated data requirements determined and approved by the Kentucky State Uniform Billing Committee and included in the UB-92 billing manual effective at the time of service.
- (b) A clean claim for dentists shall consist of the form and data set approved by the American Dental Association.
- (c) A clean claim for all other providers shall consist of the HCFA 1500 data set or its successor submitted on the designated paper or electronic format as adopted by the National Uniform Claims Committee.
- (d) A clean claim for pharmacists shall consist of a universal claim form and data set approved by the National Council on Prescription Drug Programs;

KRS 304.17A-730 – Payment of interest for failing to pay, denying or settling a clean claim as required

- Requires insurers to pay interest at the applicable rate for failure to pay, deny or settle a claim within the 30-day period established in KRS 304.17A-702.
 - This interest attaches as a matter of law.

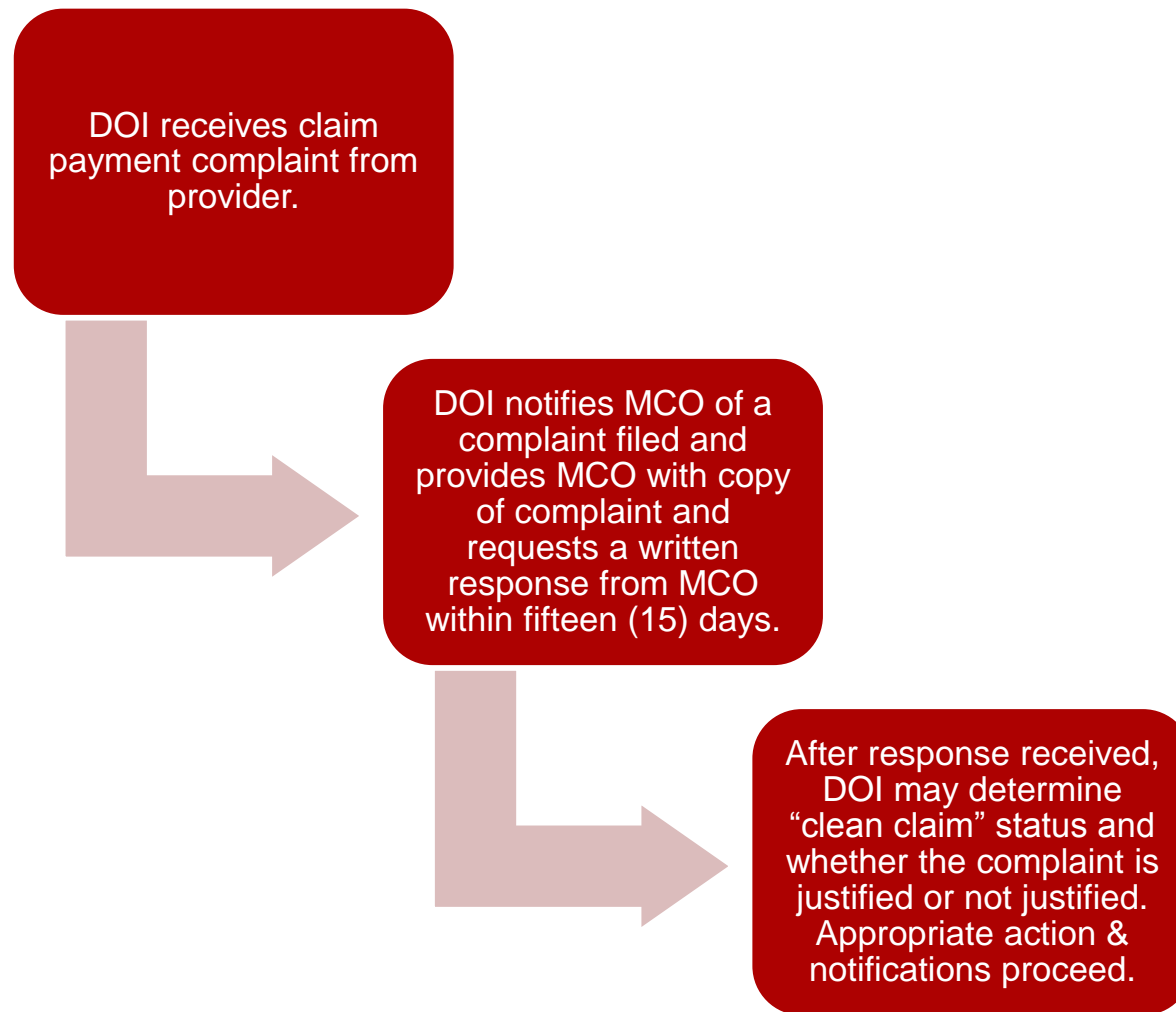
What we see

- Incomplete and improper filed claim forms
- Missing or improper modifiers
- Prior authorization issues
- Credentialing issues
- Edits in MCO claim processing databases
- Contractual payment amounts disputes
- Dual eligible and coordination of benefits
- Miscommunication or no communication

How do we move forward

- Credentials
- Understand your contract and payment amounts
- Complete the claim forms properly
- Know and understand your MCO remedy plans
 - Is this an appeal for the member—medical necessity?
 - Is this a payment amount dispute?
 - Is this a bundling issue?
 - Is this a coding issue?
- Review the EOP's and denial notices
- If confused, call the MCO Provider Relations Department
- When necessary, call or contact us

Complaint Process



What does the MPPC need to efficiently & effectively process your complaint?

- Providers
 - Completed Medicaid Prompt Payment Complaint form
 - Filed by Medicaid member—if multiple Medicaid members, you need to file multiple complaint forms
 - Claims specifically identified with a easily identifiable marking where DOI knows which services are being questioned
 - Detailed explanation of complaint—for each services complaint is being filed for
 - What services are being complained about?
 - When was it originally submitted for payment?
 - Was it denied? Was it contested? Was it returned for more information?
 - Copy of pre-authorization if applicable
 - Has MCO provided a copy of all services requiring pre-authorizations?
 - Timelines with dates and copies of correspondence

Identifiable mark to indicate the service for the complaint— *see the circle*

1500
HEALTH INSURANCE CLAIM FORM
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 09/95

KENTUCKY SPIRIT HEALTH-
CLAIMS PROCESSING DEPT.
PO BOX 400
BIRMINGHAM, MO 63640-3401

PAGE: 1

1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN FECA BLK UNV OTHER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)
BROWN KYLIEGH MAE

3. PATIENT'S BIRTH DATE
01/13/2011

4. INSURED'S NAME (Last Name, First Name, Middle Initial)
BROWN KYLIEGH MAE

5. PATIENT'S ADDRESS (Include Area Code)
222 SUMMIT DR.
PADUCAH, KY 42003

6. PATIENT STATUS
Single ☒ Married ☐ Other ☐

7. INSURED'S ADDRESS (Include Area Code)
222 SUMMIT DR.
PADUCAH, KY 42003

8. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

9. OTHER INSURED'S DATE OF BIRTH

10. IS PATIENT'S CONDITION RELATED TO:
a. EMPLOYMENT? (Current or Previous) ☒ YES ☐ NO
b. AUTO ACCIDENT? ☐ YES ☒ NO
c. OTHER ACCIDENT? ☐ YES ☒ NO

11. INSURED'S POLICY GROUP OR FECA NUMBER

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.)
SIGNATURE ON FILE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.)
SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident or Pregnancy I/M)
MM/DD/YY 01/13/2011

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE, MM/DD/YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION
FROM 01/13/2011 TO 01/13/2012

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE
17a. NAME 17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES
FROM 01/13/2011 TO 01/13/2012

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? ☒ YES ☐ NO

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (Re-use items 1,2,3 or 4 to item 24E by line)
1. 765 10 3. V30 01

22. MEDICAL RESUBMISSION CODE

23. PRIOR AUTHORIZATION NUMBER

24. A. DATES OF SERVICE FROM MM/DD/YY TO MM/DD/YY B. RATE OF SERVICE C. D. PROCEDURES, SERVICES, OR SUPPLIES (Include Unit/Quantity) E. DIAGNOSIS (ICD-9-CM) F. CHARGES G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z. AA. AB. AC. AD. AE. AF. AG. AH. AI. AJ. AK. AL. AM. AN. AO. AP. AQ. AR. AS. AT. AU. AV. AW. AX. AY. AZ. BA. BB. BC. BD. BE. BF. BG. BH. BI. BJ. BK. BL. BM. BN. BO. BP. BQ. BR. BS. BT. BU. BV. BW. BX. BY. BZ. CA. CB. CC. CD. CE. CF. CG. CH. CI. CJ. CK. CL. CM. CN. CO. CP. CQ. CR. CS. CT. CU. CV. CW. CX. CY. CZ. DA. DB. DC. DD. DE. DF. DG. DH. DI. DJ. DK. DL. DM. DN. DO. DP. DQ. DR. DS. DT. DU. DV. DW. DX. DY. DZ. EA. EB. EC. ED. EE. EF. EG. EH. EI. EJ. EK. EL. EM. EN. EO. EP. EQ. ER. ES. ET. EU. EV. EW. EX. EY. EZ. FA. FB. FC. FD. FE. FF. FG. FH. FI. FJ. FK. FL. FM. FN. FO. FP. FQ. FR. FS. FT. FU. FV. FW. FX. FY. FZ. GA. GB. GC. GD. GE. GF. GG. GH. GI. GJ. GK. GL. GM. GN. GO. GP. GQ. GR. GS. GT. GU. GV. GW. GX. GY. GZ. HA. HB. HC. HD. HE. HF. HG. HH. HI. HJ. HK. HL. HM. HN. HO. HP. HQ. HR. HS. HT. HU. HV. HW. HX. HY. HZ. IA. IB. IC. ID. IE. IF. IG. IH. II. IJ. IK. IL. IM. IN. IO. IP. IQ. IR. IS. IT. IU. IV. IW. IX. IY. IZ. JA. JB. JC. JD. JE. JF. JG. JH. JI. JJ. JK. JL. JM. JN. JO. JP. JQ. JR. JS. JT. JU. JV. JW. JX. JY. JZ. KA. KB. KC. KD. KE. KF. KG. KH. KI. KJ. KK. KL. KM. KN. KO. KP. KQ. KR. KS. KT. KU. KV. KW. KX. KY. KZ. LA. LB. LC. LD. LE. LF. LG. LH. LI. LJ. LK. LL. LM. LN. LO. LP. LQ. LR. LS. LT. LU. LV. LW. LX. LY. LZ. MA. MB. MC. MD. ME. MF. MG. MH. MI. MJ. MK. ML. MM. MN. MO. MP. MQ. MR. MS. MT. MU. MV. MW. MX. MY. MZ. NA. NB. NC. ND. NE. NF. NG. NH. NI. NJ. NK. NL. NM. NO. NP. NQ. NR. NS. NT. NU. NV. NW. NX. NY. NZ. OA. OB. OC. OD. OE. OF. OG. OH. OI. OJ. OK. OL. OM. ON. OO. OP. OQ. OR. OS. OT. OU. OV. OW. OX. OY. OZ. PA. PB. PC. PD. PE. PF. PG. PH. PI. PJ. PK. PL. PM. PN. PO. PP. PQ. PR. PS. PT. PU. PV. PW. PX. PY. PZ. QA. QB. QC. QD. QE. QF. QG. QH. QI. QJ. QK. QL. QM. QN. QO. QP. QQ. QR. QS. QT. QU. QV. QW. QX. QY. QZ. RA. RB. RC. RD. RE. RF. RG. RH. RI. RJ. RK. RL. RM. RN. RO. RP. RQ. RR. RS. RT. RU. RV. RW. RX. RY. RZ. SA. SB. SC. SD. SE. SF. SG. SH. SI. SJ. SK. SL. SM. SN. SO. SP. SQ. SR. SS. ST. SU. SV. SW. SX. SY. SZ. TA. TB. TC. TD. TE. TF. TG. TH. TI. TJ. TK. TL. TM. TN. TO. TP. TQ. TR. TS. TT. TU. TV. TW. TX. TY. TZ. UA. UB. UC. UD. UE. UF. UG. UH. UI. UJ. UK. UL. UM. UN. UO. UP. UQ. UR. US. UT. UU. UV. UW. UX. UY. UZ. VA. VB. VC. VD. VE. VF. VG. VH. VI. VJ. VK. VL. VM. VN. VO. VP. VQ. VR. VS. VT. VU. VW. VX. VY. VZ. WA. WB. WC. WD. WE. WF. WG. WH. WI. WJ. WK. WL. WM. WN. WO. WP. WQ. WR. WS. WT. WU. WV. WW. WX. WY. WZ. XA. XB. XC. XD. XE. XF. XG. XH. XI. XJ. XK. XL. XM. XN. XO. XP. XQ. XR. XS. XT. XU. XV. XW. XX. XY. XZ. YA. YB. YC. YD. YE. YF. YG. YH. YI. YJ. YK. YL. YM. YN. YO. YP. YQ. YR. YS. YT. YU. YV. YW. YX. YY. YZ. ZA. ZB. ZC. ZD. ZE. ZF. ZG. ZH. ZI. ZJ. ZK. ZL. ZM. ZN. ZO. ZP. ZQ. ZR. ZS. ZT. ZU. ZV. ZW. ZX. ZY. ZZ.

25. FEDERAL TAXATION STATUS ☒ YES ☐ NO

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? ☒ YES ☐ NO

28. TOTAL CHARGE \$ 62500

29. AMOUNT PAID \$ 000

30. BALANCE DUE \$ 62500

31. SIGNATURE OF PATIENT OR SUPPLIER (Include degrees or credentials)
David N. Schaefer, MD

32. SIGNATURE OF PROVIDER OR SUPPLIER (Include degrees or credentials)
David N. Schaefer, MD

33. ADDRESS OF PROVIDER OR SUPPLIER (Include degrees or credentials)
101 KENTUCKY AVENUE
PADUCAH, KY 42003-3401

34. ADDRESS OF PATIENT OR SUPPLIER (Include degrees or credentials)
222 SUMMIT DR.
PADUCAH, KY 42003-3401

35. APPROVED OMB 0938-0999 FORM CMS-1500 (08/05)

cant read this.

Submitting a prompt payment complaint

➤ DOI website <http://insurance.ky.gov>

✓ ***File a Complaint***

✓ ***How to File a Medicaid Prompt Payment Complaint***

❖ Paper

- *Kentucky Department of Insurance Medicaid Prompt Payment Complaint Form* and submit all supporting documentation

❖ Electronic

- DOI website allows electronic submission
 - Go to Tab— ***File a Complaint —Clean Claim Electronic Submission*** — the next step requires you to set up an E-Services Account—step by step instructions with graphics are provided in establishing an E-Services account.

DOI Medicaid Prompt Payment Compliance Branch Process

- Receive the complaint, review for attached documentation
- Enter the complaint by the individual member's name and assign a case number
 - Review the documentation to identify the number of claim lines associated with the individual member and identify which claims are in need of review.
 - Determine if additional information is needed from complaint and request if appropriate

- Notify the MCO in writing that a complaint has been received and provide a copy of the complaint to the MCO
 - The MCO is required to respond in writing to DOI within 15 days
- Upon receipt of the MCO's response, DOI will review and request additional information if necessary
 - DOI will make determination:
 - Prompt Pay or Not Prompt Pay
 - Any Willing Provider or Not Any Willing Provider
 - Justified or Not Justified

- Notify the Provider and MCO of the determination
- If MCO is responsible for paying the claim, the claim is required to be paid within 30 days with interest if applicable
- MCO provides to DOI verification of payment at time of payment

Setting up a New Medicaid Prompt Pay - Provider Submission Account

➤ To submit a Prompt pay Complaint online, you must create an account.

➤ Setting up an E-Services Account

➤ To begin the application, double click your **internet browser**.

Follow the link to the DOI Webpage at
<http://insurance.ky.gov>

Kentucky.gov KY Agencies | KY Services | Search for Search Terms

Kentucky
Department of Insurance

eServices
Secure Website

denotes external link.

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Department of Insurance

The Kentucky Department of Insurance regulates the commonwealth's insurance market, licenses agents and other insurance professionals, monitors the financial condition of companies, educates consumers to make wise choices and ensures that Kentuckians are treated fairly in the marketplace.

Our Mission: We promote sound, competitive insurance markets; protect the public through effective enforcement and regulation; and empower the public through outreach and education.

Thank you for visiting our website. We welcome your input and suggestions. If you have general questions or need our assistance, please contact us - e-mail: doiinfo@ky.gov, KY-only toll free 800-595-6053 or 502-564-3630, TTY 800-648-6056. For division-specific questions, please go to the e-mail links under Contact Us/Directions.

What's New / Recent Topics

- 2012-11 - Fraud Statistics/Convictions Activity (November)
- Insurers Must Offer Child-Only Policies
- 2012-10 - Fraud Statistics/Convictions Activity (October)
- Frequently Asked Questions for Medi-Share Members
- NAC Consumer Alert: Annuities and Veterans Pension Qualification
- Annual Statement and Other Instructions

Links

- Kentucky Essential Health Benefits

eServices

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- [Complaint Ratio](#)
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Federal Health Reform

- [Pre-Existing Condition Insurance Plan](#)

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Click the E-Services icon, located at the top right side of the page, or click on eServices link located above the search options.

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Kentucky Department of Insurance

eServices
Secure Website

denotes external link.

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Department of Insurance

The Kentucky Department of Insurance regulates the commonwealth's insurance market, licenses agents and other insurance professionals, monitors the financial condition of companies, educates consumers to make wise choices and ensures that Kentuckians are treated fairly in the marketplace.

Our Mission: We promote sound, competitive insurance markets; protect the public through effective enforcement and regulation; and empower the public through outreach and education.

Thank you for visiting our website. We welcome your input and suggestions. If you have general questions or need our assistance, please contact us - e-mail: do.info@ky.gov, KY-only toll free 800-595-6053 or 502-564-3630, TTY 800-648-6056. For division-specific questions, please go to the e-mail links under Contact Us/Directions.

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- [Health Rate Filings](#)

Federal Health Reform

- [Pre-Existing Condition Insurance Plan](#)

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This will lead you to the log in screen for E-Services.

KYDepartment of Insurance

[KYDOI Home](#) | [FAQs](#) | [Contact Us](#)

Please log in here:

Username

Password

What does eServices offer?

First time here? Please click here to register for secure access.

Forgot your password?

eServices will timeout after 15 consecutive minutes of inactivity. This is done to protect confidential information should a user forget to logout. If this happens, simply go through the logon process to continue eServices activities

Having trouble logging in? Click here for assistance.

[Click Here](#) to learn about our security.

Consumers

- [Submit Consumer Complaint File](#)

Individuals
(Licensed or pending applicants)

- Review your licensing information and account profile
- Submit requests for additional license certificates, clearance / certification letters, voluntary surrenders, address changes, name changes, license renewals, examinations, etc.
- Submit Surplus Lines Affidavits.

Others -

- View KY Department of Insurance's database based on your inquiry needs. (NOTE: This type of access is intended for KCTCS Proctors, State Agencies, etc.)

CE and Pre-Licensing Providers

- Submit Course Rosters and Individual Course Completions
- Pay outstanding fees for filings, accreditation, and account

Business Entities

- Review your affiliated individuals licensing information (i.e., addresses, examinations, license/application status, continuing education, etc.)
- Submit requests for additional licenses, clearance / certification letters, voluntary surrenders, address changes, name changes, license renewals, and designations.

Insurers

- Review your affiliated individuals licensing information (i.e., addresses, examinations, license/application status, continuing education, etc.)
- Submit financial responsibility records - E&O Legal Liability (Form 99-1) and Assumption of Insurers Legal Liability (Form 99-6)
- Submit financial responsibility cancellations - (Form 99-5)

OR

- Submit data for KY Department of Insurance's review and acceptance (NOTE:

If you have an E-Services account, enter the username and password to gain access. If you do not have an account, proceed to the next step.

If you're a first time E-Services user.....you'll need to log in and acquire a username and password.

KYDepartment of Insurance

Please log in here:

Username

Password

Click here → [First time here? Please click here to register for secure access.](#)

[Forgot your password?](#)

eServices will timeout after 15 consecutive minutes of inactivity. This is done to protect confidential information should a user forget to logout. If this happens, simply go through the logon process to continue eServices activities

Who

Consumers

- [Submit Con](#)

Individuals
(Licensed c

- Review you
account pr
- Submit req
certificates
voluntary si

You'll need to designate your username and password

When creating a username, consider establishing a specific identifiable username for each of your billing providers.

There needs to be a separate account for each billing provider.

Create New eServices User Account :

DOI must have your initial application on file **BEFORE** you create an Individual or Business Entity eServices account.

Your eServices Account Information	
Username	<input type="text"/> (Must be between 8-15 alpha numeric characters in length)
Password	<input type="password"/> (Must be between 8-15 alpha numeric characters in length, should have at least 1 number)
Verify Password	<input type="password"/>
UserType	Individual: Individual Access <input type="button" value="v"/> (Select the appropriate type of administrator insurer / business entity from the list)
Security Question	Your Mother's Maiden Name <input type="button" value="v"/>
Answer	<input type="text"/>

Username must be 8-15 alpha numeric characters in length

Password must be 8-15 alpha numeric characters, should have at least 1 number

Select the User Type “Medicaid : Medicaid MCO”

Create New eServices User Account :

DOI must have your initial application on file BEFORE you create an Individual or Business Entity eServices account.

Your eServices Account Information	
Username	<input type="text"/> (Must be between 8-15 alpha numeric characters in length)
Password	<input type="password"/> (Must be between 8-15 alpha numeric characters in length, should have at least 1 uppercase letter, 1 lowercase letter, 1 number, and 1 special character)
Verify Password	<input type="password"/>
UserType	<div> <div>Individual: Individual Access</div> <div> Business Entity: Agent Licensing Administrator Business Entity: Agent Licensing Read Only Business Entity: Agent Licensing Read-Write Insurer: Property and Casualty Administrator Insurer: Property and Casualty Read-Write Insurer: Agent Licensing Administrator Insurer: Agent Licensing Read Only Insurer: Agent Licensing Read-Write Other: Consumer Insurer: Annual Financial Statement Insurer: Long Term Care Other: Online Exam Proctor Insurer: Health Form Filing Insurer: Insurer Renewals Insurer: Financial Responsibility Insurer: Life - Paid Up Policies Insurer: NoFault Insurer: Annual Reconciliation Other: Clean Claim Medicaid: Medicaid MCO Complaint </div> </div>
Security Question	(Select the appropriate type of administrator insurer)
Answer	<input type="text"/>
Your Contact Information	
First Name	<input type="text"/>
Suffix Name	<input type="text"/>
Telephone	<input type="text"/>
E-mail Address	<input type="text"/> (Enter a valid E-mail address)
<input type="button" value="Create Account"/>	

[Don't have an account! Log In](#) |
 [Forgot Password?](#) |
 [Contact Us](#)

Select a Security question with answer...

Your eServices Account Information			
Username	<input type="text" value="Medprov2013"/>	(Must be between 8-15 alpha numeric characters in length)	
Password	<input type="password" value="••••••••"/>	(Must be between 8-15 alpha numeric characters in length, should have at least 1	
Verify Password	<input type="password" value="••••••••"/>		
UserType	<input type="text" value="Medicaid: Medicaid MCO Complaint"/>	(Select the appropriate type of administrator insurer /	
Security Question	<div><div>Your Mother's Maiden Name</div><div>Your Favorite Color</div><div>Your Pet's Name</div><div>Your Favorite Food</div><div>Name of an Elementary School</div></div>		
Answer			
Your Contact Information			
First Name	<input type="text"/>	Middle Name/Initial	<input type="text"/>
Suffix Name	<input type="text"/>		
Telephone	<input type="text"/>	Extension	<input type="text"/>

Select a security question that you can easily remember

You are now ready to enter your personal data.

Your Contact Information			
First Name	<input type="text"/>	Middle Name/Initial	<input type="text"/>
Suffix Name	<input type="text"/>		
Telephone	<input type="text"/>	Extension	<input type="text"/>
E-mail Address	<input type="text"/> (Enter a valid E-mail address)		

Enter the provider name and address information

Provider Details			
Enter the Provider Name	<input type="text"/>	NPI #	<input type="text"/>
Provider Specialty (as credentialed with DMS)	<input type="text" value="010 - Acute Care"/>	Taxonomy #	<input type="text"/>
Address Line1	<input type="text"/>		
Address Line2	<input type="text"/>		
City	<input type="text"/>	State	<input type="text" value="Select"/> Zip <input type="text"/>

Create Account

Note: the City/State/Zip must be a valid USPS match.

Note the Provider Name—each of the accounts are specific by the billing Provider name. You are unable to change this field, this is a static field.

Then Click on Create Account button. You should be ready to use eServices now.

Once you have an account, Login here

KY Department of Insurance

Please log in here:

Username

Password

First time here? Please click here to register for secure access.

Forgot your password?

eServices will timeout after 15 consecutive minutes of inactivity. This is done to protect confidential information should a user forget to

Log into E-Services

Consumer

- Sub

Individual
(Lic

- Re
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Note the menu of options offered to a Medicaid Prompt Pay Complaint account user....

eServices

- ▶ [Medicaid Prompt Payment Complaint Form - Provider Submission](#)
- ▶ [View Transaction History](#)

Click here to submit a complaint

The following form appears.

Medicaid Prompt Payment Complaint Form - Provider Submission

User Details			
Provider Name	XYZ Clinic	Provider Specialty	
Contact Name	Adabala, Veena	Phone	(502) 564-3630
Address	215 weta main st Frankfort, KY 40601		

Managed Care Organization (MCO) Name: Were you a participating provider with this MCO on the dates of services? ☒ Yes ☐ No

Member First Name: Member Mid Name: Member Last Name:

KY Medicaid Member ID #:

Claim Details			
Claim #	<input type="text"/>	Disputed Services Lines	<input type="text"/> List line #'s seperated by comma (1,3,5)
Date services rendered	<input type="text"/> (MM/DD/YYYY)	Date claim first sent to MCO	<input type="text"/> (MM/DD/YYYY)
Sent By	<input type="radio"/> Mail <input type="radio"/> Electronic		
Reason(s) for Complaint	<input type="text"/>		
Has the MCO acknowledged receipt of the claim?	<input type="radio"/> Yes <input type="radio"/> No	If yes, when?	<input type="text"/> (MM/DD/YYYY)
Has the MCO denied receipt of the claim?	<input type="radio"/> Yes <input type="radio"/> No	(If Yes, attach all documentation)	
Has the MCO made any payment?	<input type="radio"/> Yes <input type="radio"/> No		
If Yes, Payment Amount	<input type="text"/> (\$\$\$-cc)	Payment Date	<input type="text"/> (MM/DD/YYYY)
Has the MCO denied/contested the claim in writing	<input type="radio"/> Yes <input type="radio"/> No	If Yes, when?	<input type="text"/> (MM/DD/YYYY) (If Yes, attach copy)
Have you filed an appeal/grievance or dispute/re-consideration with the MCO on this claim?	<input type="radio"/> Yes <input type="radio"/> No		

Medicaid Prompt Payment Complaint Form - Provider Submission

User Details			
Provider Name	XYZ Clinic	Provider Specialty	Acute Care
Contact Name	test, test	Phone	(502) 564-3630
Address	15 west main st Frankfort, KY 40601		

Managed Care Organization (MCO) Name	<div>Select</div> <div>CareSource (Humana)</div> <div>CoverityCares of Kentucky</div> <div>Kentucky Spirit Health Plan Inc</div> <div>Passport Advantage</div> <div>WellCare Health Plans, Inc.</div>	Were you a participating provider with this MCO on the dates of services?	<input type="radio"/> Yes <input type="radio"/> No
Member First Name		Member Mid Name	<input type="text"/>
KY Medicaid Member ID #		Member Last Name	<input type="text"/>

Claim Details

Claim Details

Claim #	<input type="text" value="645"/>	Disputed Services Lines	<input type="text" value="1,2,3"/> (1,3,5)	List line #'s seperated by comma
Date services rendered	<input type="text" value="10/9/2013"/> (MM/DD/YYYY)	Date claim first sent to MCO	<input type="text" value="10/1/2013"/> (MM/DD/YYYY)	
Sent By	<input checked="" type="radio"/> Mail <input type="radio"/> Electronic	(Attach copy of original claim with any attachments sent)		
Reason(s) for Complaint	<input type="text" value="Test"/>			
Has the MCO acknowledged receipt of the claim?	<input type="radio"/> Yes <input checked="" type="radio"/> No	If yes, when?	<input type="text"/> (MM/DD/YYYY)	
Has the MCO denied receipt of the claim?	<input type="radio"/> Yes <input checked="" type="radio"/> No	(If yes, attach all documentation)		
Has the MCO made any payment?	<input type="radio"/> Yes <input checked="" type="radio"/> No			
If Yes, Payment Amount	<input type="text"/> (\$\$\$-\$\$)	Payment Date	<input type="text"/> (MM/DD/YYYY)	
Has the MCO denied/contested the claim in writing?	<input type="radio"/> Yes <input checked="" type="radio"/> No	If Yes, when?	<input type="text"/> (MM/DD/YYYY) (If yes, attach copy)	
Have you filed an appeal/grievance or dispute/re-consideration with the MCO on this claim?	<input type="radio"/> Yes <input type="radio"/> No			
If Yes, when?	<input type="text"/> (MM/DD/YYYY)	Has there been a determination?	<input type="radio"/> Yes <input type="radio"/> No	
Has the member filed for an administrative (state fair) hearing on this claim?	<input type="radio"/> Yes <input checked="" type="radio"/> No <input type="radio"/> Unknown			

Comments

Attach All Related Documents including claim forms (UB-92, EOP, HCFA-1500 etc)

Note: Please do not attach x-rays or medical records.

Select File (Only pdf files can be attached) (You can upload multiple files)

(You can add multiple claims per member by entering the claim information and click "Add Claim Details")

Has the MCO denied/contested the claim in writing ☐ Yes ☒ No If Yes, when? (MM/DD/YYYY) (If Yes, attach copy)

Have you filed an appeal/grievance or dispute/re-consideration with the MCO on this claim? ☐ Yes ☒ No

If "Yes" when? (MM/DD/YYYY) Has there been a determination ☐ Yes ☐ No

Has the member filed for an administrative (state fair) hearing on this claim? ☐ Yes ☒ No ☐ Unknown

Comments

test

Attach All Related Documents including claim forms (UB-92, EOP, HCFA-1500 etc)

Note: Please do not attach x-rays or medical records.

Select File (Only pdf files can be attached) (You can upload multiple files)

File #	File Name
1	ZeroPremiumLife081408.pdf

(You can add multiple claims per member by entering the claim information and click "Add Claim Details")

MCO Name	Member Name	Member ID	Participating Provider
Passport Advantage	Test test	6757	Yes

Select	Claim #	Disputed Services Lines	Date services rendered	Date claim first sent to MCO	MCO Acknowledged Receipt
<input type="checkbox"/> View Details	235455	1,2	10/9/2013	10/2/2013	No

Medicaid Prompt Payment Complaint Form

User Details			
Provider Name	XYZ Clinic	Provider Specialty	
Contact Name	Adabala, Veena	Phone	(502) 564-3630
Address	215 wets main st Frankfort, KY 40601		

MCO Name	Member Name	Member ID	Participating Provider
WellCare Health Plans, Inc.	John Doe	7866	Yes

Claim 1				
Reason for Complaint	Claim #	Disputed Services Lines	Date services rendered	Date claim first sent to MCO
test	67544	1,2	9/10/2013	8/9/2013
MCO Acknowledged Receipt	Acknowledge Date	Claim Denied	Claim Denied in Writing	Claim Denied Date
No		No	No	
Sent By	Payment Made	Payment Amount	Payment Date	
Mail	No			
Filed an appeal or grievance	Hearing Date	Has there been a determination	Filed for state hearing	
No			No	
Documents Attached	Comments			
ZeroPremiumLife081408.pdf	test			

After you submit the form, you will be taken to the invoice screen shown below. You must click on “Checkout to Submit Transaction / Complete Order” to complete the Transaction.

Transaction / Order Information

To remove any item from your order, click on the checkbox and press "Update Order".

Forms Completed by User: [Medpay2013]

Remove	Description	Fee(s)
<input type="checkbox"/>	Medicaid Prompt Payment Complaint Form - Provider Submission	\$0.00
Total Amount Due		\$0.00

Please note: You must checkout to complete your transaction, even if your "Total Amount Due" is 0.
If the total amount due is more than \$1500.00, you can only checkout via Debit (ACH) payment method.

Update Order

Checkout to Submit Transaction/Complete Order

Continue Shopping/Return to Menu

Cancel Order

You must click “Checkout to Submit Transaction / Complete Order” to complete the Transaction.

If you wish to delete the transaction, click on “Cancel Order”.

Transaction Details:

Your transaction has been processed and does not require any additional Payment information.
Below are the details of your transaction. You may print a copy of this for your records by clicking on the "Print copy of invoice" listed below.

Order Information		Shipping Information (if applicable)
DOI Transaction ID: 23866		
ePay Transaction ID:		
Transaction Date: 10/25/2013		
Qty	Description	Fee(s)
1	Medicaid Prompt Payment Complaint Form - Provider Submission	\$0.00
		Total Charged:
		\$0.00
Print Medicaid Prompt Payment Complaint Form - Provider Submission		
Print copy of invoice Click here to return to the main menu		

You can print a copy of an
E-Services transaction
invoice here...

Click on "Print Medicaid Prompt
Pay Complaint Form" to print a
copy of the data submitted.

Or return to the E-Services main menu
here...

Contact Information

Telephone numbers

Phone—502-564-6106 Fax—502-564-2555
Toll Free in Kentucky—800-595-6053 Option 5

E-Mail-----DOI.MCOCCompliance@ky.gov

Website <http://insurance.ky.gov>

Go to Our Divisions/Programs—Medicaid Prompt Payment
Compliance Branch

Physical Address:

909 Leawood Drive, Frankfort, KY 40601

Mailing address:

P.O. Box 517, Frankfort, KY 40602-0517

Thank you

The Department of Insurance appreciates the cooperation of the Healthcare Service Providers, the Medicaid Managed Care Organizations and the Department for Medicaid Services as we collectively and cooperatively work to manage and improve the payment of claims and the delivery of healthcare for our citizens in the Commonwealth.

Please feel free to contact us if you have any questions.